

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/23/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00201770, IN00201913, IN00202174, and IN00202576.</p> <p>Complaint IN00201770 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00201913 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00202174 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00202576 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 19, 21, 22, and 23, 2016</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Census bed type: SNF/NF: 168 Total: 168</p> <p>Census payor type: Medicare: 28 Medicaid: 114 Other: 26 Total: 168</p> <p>Sample: 04</p> <p>Kindred Transitional Care & Rehab- Greenwood was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 the Investigation of Complaints IN00201770, IN00201913, IN00202174, and IN00202576. QR was completed by 99993 on 06/24/16.	F 000			